Mesocolic plane surgery: a reliable benchmark of surgical excellence?

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Dear Editor:

We thank West et al. for their reply to our correspondence. Their efforts at implementation of change are laudable as standardisation of colonic cancer surgery is overdue. However, since cancer outcomes have been improving over the last few decades, it is difficult to attribute them to surgical technique alone. Do global improvements in radiology, medical oncology, pathology and ancillary services contribute, and if so, can these be corrected for on multivariable analysis? This would challenge the statistical significance, albeit not the clinical impact of mesocolic plane principles.

If such wide variation in practise is evident in the UK, and only 50% of operations for colonic cancer meet the definition of “internationally recognised good practise,” is specialist surgery now mandatory rather than simply preferable? Do specialist surgeons perform better oncolog-

ical clearance than their colleagues in low-volume centres? If so, does this represent evidence in favour of surgeon or institution volume rather than the specific technique of mesocolic plane surgery?

Technically adept, specialty-trained surgeons dissect in well-defined planes such that it is intuitive that there are potential outcome benefits. However, is documentation of the completeness of mesocolic excision a better quality assurance indicator than traditional metrics (e.g. lymph node yield)? The data presented to date offer little more than an affirmation that high-quality (and likely more specialised) surgery confers improved patient outcome. This is the real headline. And it is a headstone marking the end of general (non-colorectal) surgeons operating on colonic cancer.

Yours faithfully,
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